

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition  
in 3 & 22 shown on:

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

FILM No. G 1 2 APR 18 1951

Reg. Dist. No. 281

1. PLACE OF DEATH COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Inigoes</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural St. Inigoes</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>MARTHA</u> (First) <u>HENRIETTA</u> (Middle) <u>DAISY ABELL</u> (Last)		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>2-11-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>80</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard M. Abell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Sutton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <u>Elizabeth A. Smith - St. Inigoes, Md.</u>	
16. SOCIAL SECURITY No. <u>—</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) General Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

6 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from August, 1944, to 4-12, 1951, that I last saw the deceased alive on 4-10, 1951, and that death occurred at 11:30 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-15-51</u>	<u>Trinity Cem.</u>	<u>St. Mary's City, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-13-51</u>	<u>J. J. Beary M.D.</u>	<u>J. B. Robinson</u>	<u>Leonardtown, Md.</u>	

093888

RECEIVED

APR 16 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
**FOR MEDICAL EXAMINERS**

04078

Reg. Dist. No. 28<sup>2</sup>

1. PLACE OF DEATH - COUNTY <u>ST. Marks</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY <u>ST. Marks</u> STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lexington Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ST. Marks Hosp.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Abner</u> (Middle) <u>B.</u> (Last) <u>Biscoe</u>	4. DATE OF DEATH (Month) <u>4</u> (Day) <u>28</u> (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1-19-1931</u>
9. AGE last birthday <u>20</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>maid</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William T. Biscoe</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Butler</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Wm. I. Biscoe</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.

3 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. PLACE (Home, farm, factory, street, office bldg, etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR? None

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)

BURIAL 5/1-51 Holy face Great Mills, Md.

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS

4/30/51 Cacualles P.B. Robinson, Leonardtown, Md.

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED  
MAY 2 1904  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *282*

04079

1. PLACE OF DEATH COUNTY <i>St. Mary's</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>St. Mary's</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Leonardtown</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Leonardtown</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>St. Mary's Hospital</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Frances Ida Connolly</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>14</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Sept 3-1874</i>
9. AGE last birthday <i>76</i> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house keep for self</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland St. Mary's</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	13. FATHER'S NAME <i>Robert Thompson</i>	14. MOTHER'S MAIDEN NAME <i>Susie Ann Joy</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY No. (If yes, give war or dates of service) <i>no</i>	17. INFORMANT AND ADDRESS <i>William Thompson</i>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) *Fibrillation of heart Chronic*

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) *Chronic Respirator Fatty Liver*

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

#### 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Mar 25, 1951*, to *April 14, 1951*, that I last saw the deceased alive on *April 11, 1951*, and that death occurred at *3.30 p.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

#### 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

*4/15/57*

*Cannali*

*Jon C. Martingley Leonardtown Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A13

RECEIVED  
APR 17 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 222

04080

1. PLACE OF DEATH COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonardtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Alma House</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle)	(Last) <u>Curtis</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>3</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>about 1882</u>
9. AGE last birthday	<u>65</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland St. Mary's</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME <u>Rachel Mills</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>B. A. Love Sr.</u>		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) <u>Chronic Hepatitis</u>			
(b) <u>Generalized Arteriosclerosis</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr. 1</u> , 19 <u>57</u> , to <u>Apr. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Apr. 2</u> , 19 <u>57</u> , and that death occurred at <u>1 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Donald C. Cavalieri MD</u>		ADDRESS <u>Leonardtown Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 5-1957</u>	NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>	LOCATION (City, town, or county) (State) <u>Maryland St. Mary's Md</u>
DATE REC'D BY LOCAL REG. <u>4/13/57</u>	REGISTRAR'S SIGNATURE <u>Cavalieri</u>	24. FUNERAL DIRECTOR <u>Joe C. Mattingly</u>	ADDRESS <u>Leonardtown Md</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

04081

1. PLACE OF DEATH COUNTY <u>St. Marys</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St. Marys</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Valley Lee</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Valley Lee</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Frank</u> (Middle) <u>Cutchenber</u> (Last) <u>Cutchenber</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>30</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED? (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 26, 1885</u> 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor by day</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland St. Marys</u>
13. FATHER'S NAME <u>John Cutchenber</u>		14. MOTHER'S MAIDEN NAME <u>Cora Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mary V. Cutchenber</u>			

18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cerebral hemorrhage</u>	<u>2 days</u>
Antecedent cause(s) (b) <u>Hypertension</u>	<u>8 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Chronic interstitial nephritis</u>	<u>3 years</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1949, to April 30, 1951, that I last saw the deceased alive on 4/29, 1951, and that death occurred at 1 m., from the causes and on the date stated above.

SIGNATURE G. J. Thompson M.D. ADDRESS Lepington Park, Md. DATE SIGNED 5/1/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>May 3-1951</u>	<u>St. Marys</u>	<u>Valley Lee Maryland</u>
DATE REC'D BY LOCAL REG. <u>5/3/51</u>	REGISTRAR'S SIGNATURE <u>Carroll</u>	24. FUNERAL DIRECTOR	ADDRESS
		<u>Joe C. Mattingley</u>	<u>970 W W Leonardtown Md</u>

MARGIN RESERVED FOR BINDING

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MAY 4 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH - COUNTY <u>St. Mary's</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Leonardtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Chapin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Mary's Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>James</u>	(Middle) <u>Edward</u>	(Last) <u>Davis</u>
4. DATE OF DEATH	(Month) <u>April</u>	(Day) <u>12</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 17-1865</u>
9. AGE last birthday <u>85</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer none</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland St. Mary's</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Thomas L Davis</u>	14. MOTHER'S MAIDEN NAME <u>Catherine Hayden</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	16. SOCIAL SECURITY No. <u>---</u>
17. INFORMANT AND ADDRESS <u>Carroll Davis</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Wremia

INTERVAL BETWEEN ONSET AND DEATH

5 days

331X

## Antecedent cause(s)

(b)

Cerebrovascular accident5 wks

830

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

arterio sclerosis5 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 15, 1957, to April 12, 1957, that I last saw the deceased alive on April 11, 1957, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>April 14, 1957</u>	<u>Christ Cemetery</u>	<u>Chapin</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4/13/57</u>	<u>Carroll Davis</u>	<u>Joe C. Mattingly</u>	<u>100105 Leonardtown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED  
APR 17 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

04083

Reg. Dist. No. 286

### 1. PLACE OF DEATH:

County St. Mary's

City or town Brunswick  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County St. Mary's

City or town Brunswick  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Lewis Edward Dinger

### 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Josephine Dinger

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 1-4-1873

8. AGE: Years 78 Months 3 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace River Spring, St. Mary's  
(Town, county, and state)

10. Usual occupation retired

11. Industry or business system man & carpenter

12. Name Lewis Edward Dinger

13. Birthplace New York

14. Maiden name Julia Ann Herbert

15. Birthplace St. Mary's Co. MD

16. Informant Joseph C. Herbert

Address Abell MD

17. Burial Date thereof 4-18-51  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's

Location Brunswick

18. Funeral director Joseph C. Herbert

Address St. Mary's

19. 4-16-51 19 51  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 4-16-1951 at 1230 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-1-1951 to 4-16-1951

and that I last saw him alive on 4-15-1951

Immediate cause of death Pneumonia

### DURATION

4 yrs.

Due to acute leukemia

Due to 500X

Other conditions 920

Other conditions acute leukemia

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert V. Palmer 910126

M. D. or other

Address Abell MD Date signed 4-16-51

MARGIN RESERVED FOR BINDING

VS A15 9-15-15W T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 10 1957

U.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. *282*

1. PLACE OF DEATH - COUNTY <i>St. Mary's</i>		2. USUAL RESIDENCE (HOME) OF DECEASED - COUNTY <i>St. Mary's</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mechanicville</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Mechanicville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Home</i>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <i>Robert</i> (Middle) <i>William</i> (Last) <i>Johnson</i>		4. DATE OF DEATH (Month) <i>April</i> (Day) <i>8</i> (Year) <i>1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>E</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>67</i> yrs. If under 1 year: Months <i>1</i> Days <i>8</i> Hours <i>19</i> Min.
11. BIRTHPLACE (State or foreign country) <i>St. Mary's</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Johnson</i>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <i>Robert Johnson</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <i>Cerebrovascular accident</i>		
Antecedent cause(s) (b) <i>Hypertensive cardiovascular disease</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>93d</i>		
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Jan*, 19*56*, to *Apr 5*, 19*57*, that I last saw the deceased alive on *Apr 5*, 19*57*, and that death occurred at *7:30 P.M.*, from the causes and on the date stated above.

SIGNATURE *Ray Luyker, MD* (Degree or title) ADDRESS *Mechanicville, Md 4/6/57* DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>April 8-1957</i>	<i>St. Benedict</i>	<i>Stonemart Inc</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>4/6/57</i>	<i>Chas. L. ...</i>	<i>J. C. ...</i>	<i>100105</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



RECEIVED  
APR 10 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH COUNTY <b>St. Mary's</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Hollywood</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Infirmary, Naval Air Station Patuxent River, Maryland</b>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <b>Charles Robert LUX</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>April 3 1951</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>8-4-20</b>
9. AGE last birthday <b>30 yrs.</b>		10. BIRTHPLACE (State or foreign country) <b>Bethlehem, Pennsylvania</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aviation Electronicsman</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>U.S. Navy</b>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes 1944-1951</b>		16. SOCIAL SECURITY No. <b>U.S. Navy Records</b>	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <b>(a) SPONTANEOUS, MASSIVE, INTRA-VENTRICULAR HEMORRHAGE OF BRAIN, Cause Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6hrs. 29min.</b>
Antecedent cause(s) <b>(b) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</b>		
<b>(c)</b>		

### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1210 PM 3 April, 1951**, to **6:43 PM 3 April, 1951**, that I last saw the deceased alive on **3 April, 1951**, and that death occurred at **6:43 PM** m., from the causes and on the date stated above.

SIGNATURE **C.C. MUEHE** (Degree or title) ADDRESS **USNAS, Patuxent River, Maryland** DATE SIGNED **5 April 1951**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>4-6-51</b>	<b>Arlington National</b>	<b>Arlington, Virginia</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<b>4/5/51</b>	<b>C.C. Muehe</b>	<b>W.D. Robinson - Loudoun, Md.</b>	<b>673916</b>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 9 1951  
BUREAU Y. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

04686

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 287

1. PLACE OF DEATH - COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>St. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Abell</u>	
TOWN <u>Leonardtown</u>		TOWN <u>Abell</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St Marys Hospital</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Clarence Benj. Mattingly</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April - 28 - 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Oct 15 - 1943</u>
9. AGE last birthday <u>7</u> yrs. <u>6</u> Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.		10. a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Church</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland St Marys</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John J Mattingly</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Frances Brown</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr George B. Woodall</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a)

Cerebral hemorrhage2 hrs.

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

penetrating bullet wound of skull3 hrs.

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY None

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 4 28 '57 8:30 p.m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

Shot during target practice by shooter.

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion, resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 4/30/57REGISTRAR'S SIGNATURE Clarence Benj. Mattingly

24. FUNERAL DIRECTOR

ADDRESS

John C. Mattingly  
Leonardtown Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 2 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

04087

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 282

1. PLACE OF DEATH COUNTY <u>St Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>St Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonardtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonardtown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>R.F.D. #1</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Hayden Aloysius Norris</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan 9 - 1894</u>
9. AGE last birthday <u>57</u> yrs.		10. AGE last birthday If under 1 year: Months <u>2</u> Days <u>28</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer work by the day</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland St Mary's</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernard M. Norris</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Hayden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Bertman Norris</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>4/6x</u> <u>950</u> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Chronic heart failure (left)</u> <u>Pneumatic corditis cordis</u> <u>Exhaustion</u>	(a) (b) (c)	<u>3 yrs.</u> <u>3 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u> m.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	(CITY OR TOWN) (COUNTY) (STATE) <u>None</u>
HOW DID INJURY OCCUR? <u>None</u>		

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

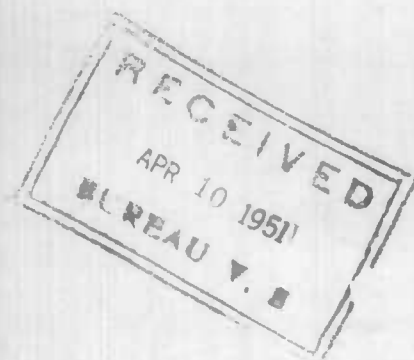
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>April 9 - 51</u>	NAME OF CEMETERY OR CREMATORY <u>St Aloysius</u>	LOCATION (City, town, or county) <u>Leonardtown Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>4/6/51</u>	REGISTRAR'S SIGNATURE <u>Camallen</u>	24. FUNERAL DIRECTOR <u>Joe C. Mattingley</u>	ADDRESS <u>Leonardtown Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

04088

Reg. Dist. No. 282

1. PLACE OF DEATH- COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Virginia</u> COUNTY <u>West Moreland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Patuxent River, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Colonial Beach</u>	
TOWN <u>Patuxent River, Md.</u>		TOWN <u>Colonial Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Infirmery, U.S. Naval Air Station, Patuxent River, Md.</u>		STREET ADDRESS <u>none</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Teresa Diane ROUSSELL</u>		4. DATE OF DEATH (Month) <u>4</u> (Day) <u>12</u> (Year) <u>1951</u>	
6. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	5. DATE OF BIRTH <u>4-6-51</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>6</u> yrs. If under 1 year Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.
13. FATHER'S NAME <u>Glen Alvin ROUSSELL</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Alma Elizabeth TATE</u>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS (Father) <u>VP24, NAS Patuxent River, Maryland</u>	

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>ATELECTASIS</u>	INTERVAL BETWEEN ONSET AND DEATH <u>6 days 2 min</u>
Antecedent cause(s) (b) <u>PREMATURITY</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	
(c)	

#### II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 6, 1951, to April 12, 1951, that I last saw the deceased alive on April 12, 1951, and that death occurred at 6:20 PM m., from the causes and on the date stated above.

SIGNATURE <u>D.M. Shook</u> D.M. SHOOK, LT MC USN	(Degree or title)	ADDRESS <u>Infirmery, U.S. Naval Air Station, Patuxent River, Md.</u>	DATE SIGNED <u>4-13-51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4-16-51</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>
DATE REC'D BY LOCAL REG. <u>4/14/51</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>[Signature]</u>	ADDRESS <u>[Address]</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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4182001

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APR 17 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 280

1. PLACE OF DEATH- COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Alabama</u> COUNTY <u>Dale</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Infirmary, Naval Air Station Patuxent River, Maryland</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Baby</u>	<u>Girl</u>	<u>STEWART</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>April 5, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday - - - yrs.
13. FATHER'S NAME <u>Herman David STEWART</u>		14. MOTHER'S MAIDEN NAME <u>Annette Zenobia MC KNIGHT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Father</u> <u>Great Mills, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Intra-cranial Injury</u>	<u>2hr 31min</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Breech delivery</u>	
	(c) <u>Prolonged labor</u>	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 0909 4-5-51, to 1140 4-5-51, that I last saw the deceased alive on 4-5-51, and that death occurred at 1140 am., from the causes and on the date stated above.

SIGNATURE B. M. SHOOK  
(Degree or title)

ADDRESS Infirmary, NAS., Patuxent River, Md. DATE SIGNED 4-5-51

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Removal</u>	<u>4-9-51</u>	<u>Newton, Alabama</u>	<u>Newton Alabama</u>
DATE REC'D BY LOCAL REG	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>4/9/51</u>	<u>[Signature]</u>	<u>[Signature]</u>	<u>Leonardtown, Md</u>

204051191406

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JUN 11 1954  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

04090

1. PLACE OF DEATH COUNTY <u>ST. Mary's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>ST. Mary's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonard Town, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Leonard Town</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Lucius</u>	(Middle) <u>WATT</u>	(Last) <u>Swales</u>
4. DATE OF DEATH	(Month) <u>4</u>	(Day) <u>12</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 25, 1877</u>
9. AGE last birthday <u>73</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>George Swales</u>	14. MOTHER'S MAIDEN NAME <u>Mary E. Cole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Mary E. Swales - Leonardtown, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Chronic Inflammation

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Generalized Arterio-sclerosis

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN ONSET AND DEATH

21. SUICIDE HOMICIDE INJURY	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from me, 1950, to Apr. 12, 1951, that I last saw the deceased alive on Apr. 10, 1951, and that death occurred at 8:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Frank A. Cavalieri MD Leonardtown Md 4/14/51

Burial 4-16-51 Exp Lady's Cemetery Madley's Neck, Md.

7/14/51 Cavalieri J.B. Robinson - Leonardtown

820105-100

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 100-10

RECEIVED

APR 17 1951

BUREAU V. S.